STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008338	A. BUILDING: _____ B. WING _____	C 05/06/2016

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SALEM VILLAGE NURSING & REHAB	1314 ROWELL AVENUE JOLIET, IL 60433

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S 000	Initial Comments STATEMENT OF LICENSURE VIOLATION: Complaint #1672218/IL85015	S 000		
S9999	Final Observations 300.610a)4 300.1210a)b) 300.1210d)6 300.1220b)3 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. 4) A policy to identify, assess, and develop strategies to control risk of injury to residents. The policy shall establish a process that, at a minimum, includes all of the following: Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by:	S9999		

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Based on observation, interview, and record review the facility failed to implement effective individualized safety/fall prevention measures; failed to appropriately assess and evaluate effectiveness of fall prevention measures; and failed to follow the plan of care for 4 (R1, R3, R5, R7) of 8 sampled residents.
This failure resulted in R3 falling and being transported to the hospital and substaining a subdural hematoma.
Findings include:
1). R3 was a 91 year old female admitted to the facility with the following diagnoses: Cerebral infarction, Paroxysmal atrial fibrillation, weakness, hypertension, history of transient ischemic attack and cerebral infarction without residual deficits, hypothyroidism, anxiety disorder, thoracic aortic aneurysm without rupture and iron deficiency anemia.
R3's annual CAA (Care Area Assessment) dated February 2, 2016 triggered for Falls documenting impaired balance during transitions.
R3's Quarterly MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of April 17, 2016 documents a BIMs (Brief Interview for Mental Status) score of 3/15 indicating cognitive impairment. The MDS further documents that R3 required extensive assistance with transfers and toilet use. The MDS also documents that R3 uses a wheelchair for mobility.
R3's Fall Risk Assessments documents the following:
February 1, 2016, R3 was scored at moderate risk
February 17, 2016- R3 scored at high risk
April 11, 2016, R3 scored at high risk
R3's POS (Physicians Order Sheet) and MAR (Medication Administration Record) for April 2016 documents the following orders:
April 7, 2016 Warfarin (Coumadin/Anti-coagulant)

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10mg daily. Lab report for April 11, 2016 - INR 4.24H (2-3), Coumadin was placed on hold. Lab reports April, 14 2016- INR 5.09 C* (Critical); April, 18 2016- INR 2.84. R3's was the restarted on Coumadin 5mg daily.
R3's April 2016 MAR/POS also documents that she was receiving Risperdal (Anti-psychotic) 0.5mg twice daily.
The facility's Incident/Accident reports for R3 documents:
R3 had a fall February 17, 2016 in the dayroom. The incident report documents that R3 was found on the floor with the wheelchair turned on its side. 4/24/16 2:20am, Resident observed on the floor between her bed and her heater, lying on her back, unwitnessed fall.
Nurse's Notes: " April 24,2016 Approx 2:20am, I was rounding and observed the resident on the floor lying on her back between the bed & heater on the right side of the bed on fall mat. She was awake, alert and oriented to self which is within resident ' s normal level of consciousness. Upon visual initial assessment the resident had a swollen upper lip with a scant amount of blood around the lips & blood on her gown. When asked if she was in pain, resident verbalized "head pain". Neuro check started & was WNL (within normal limits). Head to toe assessment completed revealing a large hematoma to the left outer forearm with no pain noted to the arm, no other injuries or pain noted.... Again R3 was sent to the hospital. "
Nurse's Notes: April 24, 2016 1200 Call from Coroner that resident passed away.
R3's Care Plans documents: January 13, 2016 R3 is a potential for bleeding or blood clot related to use of anticoagulant.
Problem start date February 23, 2016 (6 days after the initial fall) R3 is at risk for falling r/t weakness to BLE (Bilateral lower extremities).

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R3 had a fall on February 17, 2016 observed on floor left side c/o pain. Typed interventions: Give verbal reminders not to ambulate/transfer without assistance, keep call light in reach at all times, keep personal items and frequently used items within reach, observe frequently and place in supervised area when out of bed, occupy resident with meaningful distractions, Provide environment free of clutter, provide toileting assistance every 2 hours. There were interventions written on this care plan which read anti roll back brakes and anti tippers applied to w/c; High-low bed; fall mat X 2; bed/chair alarm/ assist bars X 2.
On April 27, 2016, E5 (MDS/Care Plan Coordinator) stated that the typed interventions on R3's care plan are protocol and were in place prior to the initial fall. E5 stated that the written interventions were added after the fall on February 17, 2016. E5 added that R3 was becoming progressively confused and she did not know if R3 would use the call light for assistance. E5 stated that the facility had to redirect and reiterate things to R3. E5 stated in part that the alarms were to be connected and working whenever R3 was in the bed or chair. E5 stated that the alarms were to be checked every shift and signed out on the sheets titled "CNA will initial that alarms are in place and functional every shift." E5 also stated that the sheets are to be completed every shift even on weekends except when the resident is not in the facility. E5 added that R3 does not turn her alarms off herself. E5 stated that R3 was not on a toileting program. E5 ended by stating that R3 was receiving anti-depressants, psychotropic, and anti-coagulation medications. And that R3 was confused but sometimes answered questions appropriately.
On April 27, 2016 at 2:30pm, E8 stated that he was the nurse for R3 when she fell on April 24,

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2016. E8 stated he did not know if E8 was a fall risk but she needed assistance. E8 also stated that he wasn't sure if R3 had fall prevention measures when admitted to the facility. E8 stated he would imagine that after she fell, R3 was given the alarms. E8 stated that he was making rounds on April 24, 2016 at approximately 2:20am when he came across R3's doorway and saw her on the floor. E8 stated that she was on the side where the heater was. E8 said that he could see R3's foot sticking out from the foot board. E8 added that when he glanced in he could see R3's knee hanging from the foot board of her bed. E8 stated in part that R3 was not yelling for help and there was no alarm sounding. E8 added that he was not sure if R3 was on any psychotropic medications but he knew she was receiving Coumadin. E8 stated that the CNAs are to check the alarms and ensure the sheet is signed indicating that the alarms are in place and working. E8 stated that he doesn't know what the sheets look like and the surveyor would have to ask the floor manager. E8 stated that he does not know if the CNAs checked the sheet that night because that ' s their responsibility. E8 said he had worked with two agency CNAs that shift. E8 said "We have a lot of Agency." E8 ended by stating he completed a physical assessment and no alarm was sounding.

On April 28, 2016 at 8:35am, E8 stated he documented the occurrence in the Nurse's Notes and on the Incident Report. He added that he was the first person to see R3 on the floor on April 24, 2016. E8 said R3 hit her head on the heater and was lying on her side next to the heater and blood was on the heater. E8 stated there was no one else in the room. E8 again stated he had worked with 2 Agency CNAs and can't remember their names.

Review of the first floor alarm sheets for day shift

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for April/2016 on April 27, 2016 revealed initials signed through the April 30, 2016. There were also initials noted the same as E10's (CNA) on lines where no resident name was documented. E2 (Director of Nurses) and E11 (1st floor unit manager) both stated they could not identify the initials on the logs. Review of the facility's CNA roster confirmed that the initials were the same as E10's (CNA). The initials for the night shift for April 24, 2016 next to R3's name were illegible. E11 stated the facility does not require signature of the CNAs to verify initials, only nurses. E11 stated she never met the Agency CNAs. The facility's unit assignment sheet revealed that Z1 (Agency CNA) worked with R3 the night she fell. The facility was asked to provide the file for Z1, E2 stated the facility does not keep files on Agency staff. On April 28, 2016 The facility was asked to contact Z1. E3 stated he attempted but was unable to reach her through the Agency.
On April 27, 2016, E6 (CNA) stated that she worked with R3 and she was pleasant but needed redirection. E6 stated that R3 had bed and chair alarms and needed assistance with toileting. E6 also stated that R3 was confused. E6 added that R3 slept in the bed by the heater and she heard that she had fallen.
On April 27, 2016 at 1:40pm, E7 (LPN/Licensed Practical Nurse) stated that R3 was receiving anti-coagulant therapy and needed assistance toileting. E7 stated R3 had a bed and chair alarm in place. E7 stated R3 would move around the day room but was not at risk for falls prior to the fall on February 17, 2016. E7 also stated he was not sure if fall measures were in place prior to the fall on February 17, 2016. E7 stated R3's alarms were given after the fall on February 17, 2016. E7 added it is the responsibility of the CNAs to check if the alarms are in place. E7 stated he received morning report from E8 (LPN) on April

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25, 2016 and he stated R3 had fallen and hit her head and was in ICU (Intensive Care Unit).
On February 27, 2016 at 1:51pm, E9 (Restorative Aide) stated R3 had no fall interventions in place prior to February 17, 2016. E9 stated "no we're not supposed to put interventions in place before hand, usually the interventions come after the person has had a fall or is a fall risk." E9 stated R3 received a chair and bed alarm after her fall on February 17, 2016. E9 stated R3 tries to get up a lot on her own. E9 stated the alarm checks have to be signed out and that the "CNA will initial that alarms are in place and functional every shift logs." E9 stated she doesn't know if R3 was a fall risk prior to the fall on February 17, 2016 but she was agitated.
On April 28, 2016 at 10:04, E3(Assistant Director of Nursing) stated he could not verify the initials on the alarm signature logs for R3 on April 24, 2016.
On April 28, 2016 at 10:12am, E10 (Nurse Aid) stated she works on the 1st floor. E10 stated she received training on the bed and chair alarms and the sign out log. E10 stated the CNAs are to check the alarms and then sign the sheet indicating they are in place and functioning properly. E10 stated "if you don't check them, you don't sign them." E10 stated the procedure is to ensure the alarms are attached, hooked up, and functioning. E10 also stated the staff are to take the alarm off and put it back together and ensure its working.
On April 28, 2016 at 10:25pm, E3 provided training on mechanical lifts and gait belts and stated this was all the training Z1 received from the facility. There was no documented training on the use of safety alarms and E3 also stated the facility does not keep files on Agency CNAs.
On April 28, 2016 at 1:36 the facility's final investigation report dated April 28, 2016 was

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provided by E3. The facility's Incident Investigation Summary documents R3 was admitted to the local hospital with subdural hematoma. The report also documents the Unit manager interviewed Z1. The final investigation report documented R3's bed alarm was not sounding at the time of the fall.
On April 28, 2016 at 2:06pm, E12 (Social Services Director/Quality Assurance QA) stated R3's fall on February 17, 2016 was discussed in the weekly focus meeting. According to E12 there was no follow up meeting to discuss effectiveness of interventions.
On April 28, 2016 at 2:20pm, E13 (Human Resources Director/QA) stated she has not been to the last meetings. E13 also stated she has not been in any meetings that discussed R3's fall or effectiveness of interventions since the fall on February 17, 2016.
On April 28, 2016 at 2:30pm, E11 stated she spoke with Z1 on the phone this week. E11 stated there was an initial meeting after R3 fall to discuss new interventions. However, according to E11, there were no further meetings to discuss effectiveness of interventions. E11 also stated she is responsible for adding interventions and following up on falls, but she is not on the QA team. At 2:59pm, E11 added that when she spoke with Z1, Z1 informed her that she last saw R3 at midnight on April 24, 2016 and could not remember if R3's alarm was functioning.
On April 28, 2016 at 2:45pm Z2 (Attending Physician) stated he was aware of R3's fall on April 24, 2016. Z2 stated R3 needed to be on anti-coagulants for atrial fibrillation. Z2 stated he spoke with the family and informed them this would cause increased risks for falls. Z2 stated it is his assumption that the fall led to the subdural hematoma that R3 sustained, but he's not really sure because he doesn't have access

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to the hospital information.
2). R1 is an 80 year old female admitted to the facility with the following diagnoses: hypertension, urinary tract infection
R1's Annual MDS with ARD February 2, 2016 documents: Inattention and disorganized thinking. Transfers- extensive assistance (staff provide weight-bearing support), one person physical assistance.
R1's Physician Order Sheet for Feb/2016 documents: bed and chair alarm and fall mat at bedside.
2) On April 27, 2016 during tour of the facility with E4 (Assistant Director of Nursing) and E11 (Nurse) starting at 8:52am, R1 was noted in her wheel chair with a helmet on. E11 stated R1 has the helmet because she's had multiple falls. R1's wheel chair did not have an alarm in place and an alarm was not on R1's bed.
On April 28, 2016 at 11:23am, R1 was noted in her chair at a table, sitting alone. There was an alarm on the back of R1's chair and out of her sight. The alarm however, was not attached to R1. The clip was attached to the cord it hung from. E7 (Nurse) confirmed at that time that the fall alarm was not properly attached to R1. E7 stated that the clip should be attached to R1. E7 stated "In a few minutes, she will get up and walk by herself." E7 attached the alarm clip to R1's clothing.
R1's care plan was reviewed with E11 and documented the following interventions: observe for functional decline, observe, and report all unsafe conditions immediately, place call light within reach at all times, position for comfort, provide extra pillows if needed, may use a wedge cushion for positioning. E11 stated that these interventions are standard for every resident.
R1's Incident/Accident Reports were reviewed with E11 and documents the following

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falls/incidents:
August 14, 2015 noted sitting on floor in her room. E11 stated that R1 misguided the distance to the chair. According to E11 the intervention was Optometry consult. Per E11 the Optometrist stated R1 did not need glasses. E11 stated no further interventions.
August 23, 2015 Bump on forehead. Intervention according to E11 was to give her a helmet.
September 25, 2015 Staff getting chair for her to sit and resident fell, intervention according to E11 was monitor sleep pattern and put her down for a nap because her gait is unsteady.
October 19, 2015 Noted on floor by CNA, intervention- move closer to nursing station. When asked to speak to the CNA, E11 stated that E14 (CNA) no longer works for facility. When asked about the facility's incident investigation, E11 stated she can't recall interviewing E14.
October 29, 2015 Resident got out of bed, jerked and fell. According to E11, E7 responded to R1's alarm, but she jerked and begin falling while E7 lowered her to the floor. When asked what interventions were placed, E7 stated to continue to monitor.
April 10, 2016 3:00am Resident grabbed a pill crusher off the med cart & dropped it on her foot. Unable to bear weight to foot. Intervention. Staff to monitor for swelling bruising and pain.
3) On April 29, 2016 on tour of the facility which began at 9:30 am the following were observed: R5 was in a chair in activities. There was a chair alarm on the chair. The alarm however, was not attached to R5. E16 (Activities Aid) stated it should be clipped. E16 then clipped the alarm to R5" clothing. R5's care plan documents 3/10/16: slid from his wheel chair in the common area and landed face down on the floor. Orders received to send to ER (Emergency Room) for evaluation. Hematoma obtained to left side of forehead. The

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care plan documents Mattress sensor alarm. Neither the care plan nor the POS documented interventions for the alarm to R5's chair.
R7's bed was in the hallway while staff worked in her room. On her bed was a bed pad alarm. R7 was located in activities. R7 was sitting in a reclining chair. There was no alarm on the chair. E17 (Activity Aid) searched the chair and did not find an alarm. R7's Incident/Accident report dated April 11, 2016 documents that R7 was found on the floor mat in her room face down. E7's plan of care documented a goal date of January 30, 2016; bed and chair alarm. The care plan did not document follow up after January 30, 2016.
R3 ' s History of Present Illness dated 4/24/14 by hospital #2 documents: Nursing home staff found the patient at the foot of her bed, hypoxic with shallow breathing, and staff is unsure the duration of time the patient was down. Upon EMS (Emergency Medical System) arrival, the patient was immediately intubated.
R3 ' s Computed Tomography (CT scan) from hospital #1 dated March 31, 2016 documented: no acute intracranial hemorrhage, mass effect, or evidence of an acute ischemic infarct.
R3 ' s CT scan from hospital #2 dated 4/24/14 documents: Large right sided hematoma with associated transfalcine and questionably transtentorial.
The facility's policy titled "Resident Falls Investigation/Prevention documents:
-The Director of Nursing or designee will investigate all resident falls. This investigation will include the resident's diagnosis, whether the resident is at risk for falls, previous history of falls, cause and circumstance of fall, time, date, location of fall, witnesses, and any appliances or devices used.
-All resident falls are reviewed weekly in the Resident Focus Meeting with the interdisciplinary

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	IL6008338	A. BUILDING: _____ B. WING _____	C 05/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM VILLAGE NURSING & REHAB	1314 ROWELL AVENUE JOLIET, IL 60433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12 team to ensure that appropriate interventions are implemented, communicated and care planned. -Data on resident falls is collected, analyzed and reported to the Quarterly QA Committee to evaluate and to make recommendations regarding changes in the facility's environments and /or practices. (A)	S9999		

IMPOSED PLAN OF CORRECTION
NAME OF FACILITY: SALEM VILLAGE NURSING & REHABILITATION
TYPE OF SURVEY: COMPLAINT#1672218/IL85015
DATE OF SURVEY: May 6, 2016

300.610a)4
300.1210a)b)
300.1210d)6
300.1220b)3
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility.

4) *A policy to identify, assess, and develop strategies to control risk of injury to residents. The policy shall establish a process that, at a minimum, includes all of the following:*

Section 300.1210 General Requirements for Nursing and Personal Care

a) *Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning*

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis

Attachment B
Imposed Plan of Correction

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

Section 300.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.* (Section 2-107 of the Act)

This will be accomplished by:

I. The facility will implement effective individualized safety/fall prevention measures and appropriately assess and evaluate effectiveness of fall prevention measures, and follow the plan a care for all residents. Any significant changes will immediately be informed to the resident; consult with the resident's physician; and if known, notify the resident legal representative and family member when there is an accident involving the resident which has the potential for requiring physician intervention; a significant change in the resident condition (physical, mental, or psychosocial status – i.e., deterioration in health, mental, or psychosocial in either life threatening conditions or clinical complications); a need to alter treatment (i.e., need to discontinue an existing form of treatment, including safety/fall prevention measures due to adverse consequences, or to commence a new form of treatment); and.

II. All nursing staff will be inserviced on the facility's policy for assessing and evaluating the effectiveness of fall prevention measures, and following a plan of care for all residents. Additionally, inservicing will be conducted regarding notification of the Director of Nursing (DON) and/or the Nurse Leader on call after hours and on weekends regarding falls and resident change of condition to ensure thorough assessment and notification have been done to resident physician and legal representative.

III. The Director of Nursing (DON) and/or Clinical Nurse Leaders will audit documentation in the medical record for compliance for compliance weekly for six (6) weeks and then quarterly in the Quality Assurance meetings. Audits with negative outcomes will result in further education for staff involved and/or possible disciplinary action.

IV. Documentation of in-service training will be maintained by the facility.

V. The Administrator, Director of Nurses, and Quality Assurance Committee will monitor Items I through V to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Ten (10) days from receipt of this Imposed Plan of Correction.